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September 2003

Sexual Partner Counseling and Referral Services (PCRS)

Information for Navy Health Care Professionals

Sexual Health and Responsibility Program (SHARP)

Navy Environmental Health Center
Bureau of Medicine and Surgery

Foreword

This document is derived in large part from guidance and training documents developed by the Centers for Disease Control and Prevention (CDC), National Center for HIV, STD, and TB Prevention, Atlanta, GA, to whom SHARP is greatly indebted.

The purpose of this document is to provide information to Navy medical professionals serving Department of Defense health care beneficiaries regarding the notification and counseling of sexual partners of patients or clients who have been diagnosed with sexually transmitted infections. ***SHARPFact*** fact sheets designed to assist the infected client with partner notification and assist clients and their partners with future risk reduction are included.

This document may be downloaded from the SHARP internet website.

Comments on this document are encouraged and may be forwarded to:

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Views and opinions expressed are not necessarily those of the Department of the Navy

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Summary of Changes

To NEHC-HP-TM 6100.02 dated (final date)

None. First issue of this document.

Cognitive Learning Objectives

Partner Counseling and Referral Services (PCRS)

Upon completion, the student will be able to **identify** and **discuss** basic facts concerning:

- ✓ PCRS purpose
- ✓ Contact tracing periods
- ✓ PCRS concepts
  - o PCRS is voluntary
  - o PCRS confidentiality
  - o Client-centered counseling
  - o PCRS is on-going
- ✓ PCRS options
  - o Provider Referral
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- ✓ PCRS steps
  - o Transition
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  - o Investigate
  - o Notify
  - o Prevention Counseling
  - o HIV test decision
  - o Link to other services
  - o Follow-up

Achievement of these learning objectives is measured by scoring not less than 80% correct on the 33-question written examination included herein.

Continuing Education Credit

Medical Corps

Classroom version only: Naval Medical Education and Training Command, Bethesda, Maryland designates this educational activity for a maximum of 4.5 Category 1 credits toward the AMA Physician's Recognition Award. NMETC approval # is 2003-35.

Nurse Corps

Self-study version: The Naval Medical Education and Training Command, Bethesda is accredited as an approver of continuing education in nursing by the American Nurses Credentialing Center's Council on Accreditation and approves this course for 3 contact hours of Educational Activity I credit. The approval number is 020913.

Navy Independent Duty Corpsmen

Self-study version: 1.5 CEUs. (Naval Medical Education and Training Command Ltr 23 Sep 02; Ser OE2564).

Classroom version: 5 CEUs (NMETC Ltr 23 Jun 03; Ser OE1656).

Certified Environmental Health Technicians / Registered Sanitarians

Self-study version: NEHA approved for 1.5 contact hours.

Classroom version: NEHA approved for 5 contact hours.

Certified Health Education Specialists
(pending)

Other Professions
Students are responsible for contacting their own respective professional organizations to determine appropriate category and documentation requirements.

Navy CANTRAC data: CIN B-322-2223; CDP 760M; Short Title PCRS.

Sexual Partner Counseling and Referral Services (PCRS)

Terminology
Partner counseling and referral services **(PCRS)** is a term that has been used since the early 1990's. Terms used previously were "partner notification" (1980's) and "contact tracing" (1930's). For the purpose of this document, a "**provider**" is any health care worker (doctor, nurse, Independent Duty Corpsman, Preventive Medicine Technician, etc.) tasked to conduct PCRS activities. A "**client**" is the person or patient infected with a sexually transmitted infection (STI) whose sexual or needle-sharing partners may have been exposed to the infection. The provider and client terminology has been adopted here because it is used in the current national guidelines.

Purpose of PCRS
Recent research (St Lawrence, et al 2002) demonstrates that "few physicians engage in partner notification, and most instruct patients to self-report to the health department or notify partners themselves. This reliance on partner notification represents a gap between common practice and our knowledge of its effectiveness".

Partner Counseling and Referral Service (PCRS) is a set of activities intended to alert people exposed to STIs and facilitate appropriate counseling, testing, and treatment. Each patient infected with an STI shall be informed of the importance of notifying their sexual partners and encouraging them to promptly seek medical evaluation for the exposure.

PCRS is only one element of a comprehensive STD/HIV prevention effort. PCRS is typically provided in conjunction with other essential STD prevention services. A comprehensive STD prevention effort includes:

- Education and prevention counseling of those at risk on ways to reduce risk
- Detection of asymptomatically infected individuals
- Effective diagnosis and treatment of infected individuals
- Partner counseling and referral (PCRS)
- Immunization of persons at risk for vaccine-preventable STDs

For example, PCRS is typically conducted in conjunction with **risk reduction counseling**. By using a **client-centered** approach, providers can help clients reduce their future risk of infection and negotiate a plan to facilitate counseling, testing, and treatment of their partners. Studies have shown that a client-centered counseling approach can result in behavior change, thereby decreasing the likelihood of future infection. In a study by Hoxworth et al (2002) partner notification was associated with increased condom use by index clients and partners.

Using **open-ended questions** is an effective strategy for gaining a great deal of information in a short time, for uncovering relevant feelings, issues, and circumstances, and for engaging the client in the conversation. Good open-ended questions begin with "who", "what", "when", "where", and "how". **Polite imperatives** such as "give me", "tell me", "explain to me", and

"describe" are also effective. "Why" questions should be avoided because they may communicate disapproval and inhibit open discussions, such as "Why did you do that?"

Some Navy providers have expressed concerns about their ability to effectively counsel clients of the **opposite sex**. However, research has demonstrated that there appears to be no correlation between the gender or ethnicity of the provider and success in partner notification programs (Hennessy, et al 2002). There have also been concerns that PCRS for HIV infected clients may actually be counter-productive because PCRS may result in **broken relationships** and the formation of new relationships (exposures of new / more people). These concerns seem unfounded based on studies by Hoxworth et al (2003) and Kissinger et al (2002).

Benefits of PCRS

The client benefits from **c**ounseling and treatment. He/she also is given an opportunity to gain peace of mind by fulfilling responsibility to partners without revealing his/her own infection status.

Partners benefits by learning about their real risk (which partners may underestimate, misunderstand, deny or be unaware of). They also receive the impetus for entering counseling and/or testing (where partners may learn of own infection for first time). They receive referral to counseling and support services (e.g., family planning and related decisions; emotional problems; addictions; other issues) and opportunity for behavior change (due to prevention counseling and increased awareness of risk). This can help them reduce the likelihood of acquiring or transmitting infections in future. *For partners who are already HIV-infected and unaware of their status, they have the o*pportunity to enter prevention case management or other needed services and to avoid inadvertent transmission to partners or unborn children.

In addition to the benefits realized by exposed and potentially infected partners, PCRS may also have prevention benefits at the **community** level in reducing STI transmission by identifying sexual networks at high risk. Interventions may then be more effectively directed, and risks within the network reduced. The effectiveness of partner notification is theoretical but not well documented. However, according to the Centers for Disease Control and Prevention (CDC), PCRS is likely to be highly cost-effective in the case of HIV, as is illustrated in the following analysis:

> "Assuming an estimated current $154,402 lifetime cost in the United States of a person acquiring HIV infection and eventually dying from HIV-related illness and a conservatively estimated average $3,205 cost of PCRS to reach one infected person, PCRS must prevent 1 infection out of every 51 HIV-infected partners reached through PCRS to be cost-effective. As PCRS links HIV-infected partners to client-centered counseling and other interventions proven or likely to be effective, this appears to be a threshold relatively easy to achieve by programs. Greater effectiveness, such as preventing only 2 or 3 infections for every 51 HIV-infected partners reached through PCRS, would convey substantial cost savings to society." (CDC, 1998)

Deciding which partners should be referred

It is not usually necessary or fruitful to notify every sexual partner of every client. Deciding which partners should be notified is based upon the STI, the client's sexual history, and the likelihood of reaching the partner.

- STI and the client's sexual history. Table 1 contains a summary of recommendations and requirements. In addition to the guidelines in the Table, providers are strongly encouraged to determine and comply with partner notification requirements of their locality and state.

Likelihood of reaching the partner. Regarding the likelihood of reaching the partner, two conditions should be considered when prioritizing the investment of healthcare resources in partner notification efforts.

The first condition is the quality of the information about the partner. For example, partners for whom the client cannot or does not provide adequate identifying or locating details will not likely be found. Providers must determine whether an effort is worthwhile in such cases.

The second condition involves the policies and practices of the cognizant public health authority. For example, notifying local civil public health authorities of the partners of clients infected with chlamydia may not be cost-effective if the local authority has a policy of following up on only syphilis and HIV cases. Providers are strongly encouraged to contact and closely network with local and state public health authorities to determine and comply with appropriate laws and policies. Military public health authorities who are informed about named partners who are active duty members assigned within their jurisdiction will always attempt notification (if appropriate according to the parameters of Table 1).

Table 1 - Contact Tracing Periods

based on
CDC STD Treatment Guidelines 2002; MMWR 51;RR-6, 10 May 2002,
CDC Partner Counseling and Referral Services Trainers Manual, 2002, page T4-17,18, and
SECNAVINST 5300.30C, Management of HIV-1 in the Navy and Marine Corps, 14 March 1990, page 8-10

Chancroid	10 days
Chlamydia	60 days (or most recent partner if >60 days)
Genital Herpes	current sex partners
Gonorrhea	60 days (or most recent partner if >60 days)
Granuloma Inguinale	60 days
Hepatitis B, acute	within 14 days after the most recent sexual contact
Hepatitis B, chronic	No contact time period specified. Minimally, current sexual partners, needle-sharing partners and non-sexual household contacts should be offered hepatitis B vaccine.
Hepatitis C	Long-term, steady sex partners should be informed of the low but present risk of transmission and be offered counseling and testing.
HIV	Options and considerations: 1 year back: This time frame is short enough to have the greatest impact on disease transmission with most-recently-exposed partners, including current and steady partners. It allows for early medical intervention with those who may have been infected unknowingly. It provides the best chance of actually finding partners since locating and identifying information in the client's memory is fresher and because partners are less likely to have moved or changed work. It makes the best use of limited resources. Back to 6 months before last negative HIV test: For clients who have tested negative in the past, the negative test marks the last time the client is thought to have been free from infection. Because the seroconversion window period is probably 6 months or less, providers should also inquire about partners in the 6 months before the negative test. As far back as the client requests: The provider should be willing to facilitate notification of all the potentally exposed partners mentioned by the client. More than 1 year: Some clients may have a sense of when they became infected or for some other reason may be concerned about partners from further back than one year. Spouses: SECNACVINST 5300.30C requires that spouses of HIV positive military reservists be provided notification, counseling, and testing.
Human Papillomavirus (genital warts)	"Examination of sex partners is not necessary…" although "…sex partners…may benefit from examination to assess the presence of genital warts and other STDs." "Female sex partners of patients who have genital warts should be reminded that cytologic screening for cervical cancer is recommended for all sexually active women". (see page 56 of MMWR 51;RR-6, 10 May 2002)
PID	60 days
Pubic lice	one month
Lymphogranuloma Venereum	30 days
Nongonococcal Urethritis	60 days
Scabies	one month
Syphilis, primary	3 months, plus duration of symptoms
Syphilis, secondary	6 months, plus duration of symptoms
Syphilis, early latent	1 year
Trichomoniasis	"sex partners should be treated"

HIV and Spouse Notification. SECNAVINST 5300.30C, Management of HIV-1 in the Navy and Marine Corps, contains detailed policies on the notification of named partners of HIV infected members (paragraph 12a(1)), and the notification of spouses of HIV-infected DoD reservists (whether they are named as partners or not) (paragraph 12c). This document is available on the SHARP internet website at http://www-nehc.med.navy.mil/hp/sharp.

> Note: Providers may be familiar with Public Law 104-106 (Ryan White Care Act Amendments of 1996) which requires States that receive Ryan White Care Act funding to make a good faith effort to notify current and previous spouses (married within the previous 10 years of the date of diagnosis). The CDC describes a good-faith effort as (1) asking all HIV-infected clients if they have a current or past marriage partner(s), (2) notifying these partners of their possible exposure to HIV, except in situations when, in the judgment of public health officials, there has been no sexual exposure of a spouse to the known HIV-infected individual during the relevant time frame; (3) referring them to appropriate prevention services; and (4) documenting these efforts. Technically, **DoD** healthcare activities are **not** affected by this law, since Ryan White grants are not received. Providers are strongly encouraged to determine local and **State laws** in this regard. Disclosure of health information to a potentially exposed person by military health officials is authorized – see DoD(HA) Military health System Notice of Privacy Practices at http://www.tricare.osd.mil/hipaa/lang-booklets.htm.

Potential partners that are not named. In rare cases, the provider may know of a partner at risk even though the client has not identified that partner. Within DoD regulations, the compilers of this document are aware of only one circumstance in which a provider has a definitive duty to inform an unnamed potential partner of a potential exposure to an STI – the HIV-infection military reservist spouse notification mentioned above. Whether or not a legal "duty to warn" other partners exists is best determined by reviewing applicable **State laws**. Providers should also be mindful of their duty to protect the privacy of the client's personal medical information.

PCRS Concepts

PCRS is voluntary.

No person can be forced to disclose the names of his/her partners. PCRS relies on the willing participation of the client and their partners. It can never be made mandatory or coercive. Attempts at coercion are unethical and generally impractical. Coercive strategies erode trust and cooperation. Anecdotes occasionally circulate regarding the use of discipline or quarantine as a method of STD prevention. An example might be the Sailor denied a liberty port call because he became infected. Providers are reminded that the use of discipline or quarantine may have negative effects on healthcare-seeking behavior. The infected patient that fears the healthcare provider may avoid or delay treatment or self-treat, leading, in some cases, to asymptomatic carrier states and serious disease sequelae. Policies of discipline, quarantine or restriction of liberty for the purpose of STI prevention may be counterproductive and are strongly discouraged.

Providers can encourage clients to participate in PCRS by fostering rapport and an atmosphere of trust and mutual respect. People are most likely to willingly participate in PCRS when they

understand the process and appreciate the benefits to themselves and their partners. PCRS efforts are more successful when providers communicate a genuine concern for the overall well-being of the client and their partners. Client-centered counseling techniques are highly recommended for developing this relationship.

Providers must protect confidentiality.

Some clients may be reluctant to participate in partner referral because of concerns over the ability of the health system to maintain their confidentiality. It is natural for a client to be sensitive about his or her personal sexual health information. This sensitivity may be heightened for military members who fear workplace implications of their infection. People who may be especially concerned about the privacy of their information include those who are in sensitive occupations or leadership positions, married patients, and those who fear their behavior may be a violation of laws or regulations. The provider should ensure clients that their privacy will be strictly protected. Health information privacy regulations have been designed to protect patient confidentiality. For example, the privacy of information obtained from a service member during or as a result of the HIV/STD treatment, prevention counseling session, or the epidemiologic interview is protected by BUMED Manual of Medicine (Section VI, Medico-Legal Issues, Articles 16-35 through 16-41), and by SECNAVINST 5300.30C, Management of HIV-1 in the Navy and Marine Corps (paragraphs 12, 14 and 15). In some cases, the provider may need to explain these regulations and processes to encourage participation by the client who is unwilling or unable to personally notify his or her partners.

All attempts to make contact with a partner should be confidential. This is often difficult because other community members might ask the purpose of the provider's call or visit and why he or she is attempting to make contact. Nevertheless, providers should not reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions an STI exposure as the reason for attempting to make contact. In addition, no other information should be revealed that might lead to others learning the reason for the contact or that might otherwise lead to disclosure of sensitive information or to a breach of confidentiality. As each partner is located, he or she should be informed privately and face-to-face, if at all possible. However, if the person refuses to meet with the provider, informing a partner by telephone might become necessary. In such situations, only limited information should be provided to the partner, and the goal still should be to arrange a face-to-face meeting if at all possible. Regarding HIV, informing a spouse by telephone should only be done as defined in SECNAVINST 5300.30C and by state and local jurisdictions, and after every step has been taken to ensure that the correct person has been located, is on the telephone, and others are not listening. Further attempts should be made to arrange a meeting in person.

The original infected client will sometimes inquire about the results of the PCRS provider's activities regarding his or her partners. The provider, when requested, can reveal whether a particular partner has been informed of his or her exposure, but must not reveal any confidential information about that partner, including whether the partner decided to be tested or whether he or she is infected. Of equal importance is not revealing any identifying information about the original client to the partner, including the person's sex, name or physical description, or time, type, or frequency of exposure.

Suggestions for protecting confidentiality under a variety of circumstances are given in Figure 1.

Although the PCRS provider may need to document the results of his or her activities, confidentiality must still be maintained for all persons involved. Information that identifies partners should be kept locked in a secure location. Client and partner information, other than the official record, should be destroyed when current PCRS activities are concluded (unless otherwise required by DoN or state practice).

States have varying legal requirements about reporting situations such as those involving violence or child abuse. The PCRS program must comply with DoD and DoN policies, relevant state laws and local regulations.

Figure 1 - Methods to Protect Confidentiality
adapted from CDC 1999, PCRS Training Participant's Manual, Handout 3-1

When talking with the STI-infected client:
- Never reveal whether a partner decided to be tested.
- Never tell the client the partners' test results.
- You may reveal whether a particular partner has been informed of his or her exposure.

When talking with partners:
- Always confirm identity of partner.
- Always find a private site and, only then, notify them of the possible exposure.
- Never identify the client by name, gender, physical description, race, age, type of exposure (sex or needle-sharing), dates of exposure, or location of exposure.

When talking with "third parties" (such as roommates, parents, neighbors, spouses):
- Never give information about why you're looking for the person.
- Limit your remarks to, "This is about a health matter," or "This is personal and important."

When leaving written messages, especially while seeking partners:
- Leave message in a sealed envelope – you may write "confidential and urgent" on the envelope.
- In the letter or notice, write only, "This is an urgent health matter."
- Never leave your business card if it suggests you are in preventive medicine or disease control.

When using the telephone:
- Always ensure that you are speaking with the correct person.
- Always verify that the person is in a private setting.
- Always ensure that no one can overhear your end of the conversation.

When handling written records:
- Keep partner names and identifying information locked up.
- Refer requests for client or partner information to appropriate medicolegal authorities.
- Never take records out to the field.
- Never leave notes or papers in your car, home, or other unsafe place.

When talking with your own work colleagues:
- Never discuss clients or partners unless there is pressing need to do so.
- Always protect the identity of clients and partners during case reviews.

When talking with your family, friends, or others outside the workplace:
- Keep work discussions to a minimum.
- Never reveal any identifying features of a client or partner.

Client-centered communication is most effective. Client-centered communication means that the interaction between the provider and the client is focused on the client's issues and circumstances. This interaction differs from "canned" information-giving and advice-giving. Provider skills that are useful in this regard include:

Focus on feelings. To be successful, the provider should determine and acknowledge the client's relevant feelings about the issues surrounding referral of their sexual partners. Minimizing the client's feelings or failing to understand them may hinder effective communication and referral. An effective interaction requires the candor and active involvement of the client. The provider must seek to understand what issues may motivate or inhibit the client in successful partner referral. To accomplish this, the provider must be willing to ask about and listen to the client's concerns and beliefs and respond effectively to them.

Manage your own discomfort. The PCRS task requires providers and clients to discuss issues that may be very personal and even painful. Both the provider and client enter the interaction with their own set of values, biases and beliefs. It is expected that some clients will disclose behavior, values, or circumstances that cause discomfort in the provider. This discomfort is natural and expected. But, if the provider reacts adversely, communication with the client may be hindered and partner referral efforts may suffer. An uncomfortable provider may react by avoiding difficult issues, hurrying the session, or dictating referral options. These reactions will not likely result in successful partner referrals. Providers should manage their discomfort and avoid verbal and non-verbal reactions that may shut down communication. A non-judgmental and empathetic attitude is helpful. At the end of an effective session, the client should have no idea what the provider's biases are. Providers might remind themselves that they can effectively help clients even though they may hold different values, biases and beliefs.

Set boundaries. Providers seek to positively influence the attitudes and actions of their clients, but intuitively know they do not control the client's behavior at any time – before or after the interaction. Just as the provider should not accept responsibility for client choices, providers must acknowledge that clients may not choose the referral options and plans the provider would prefer. Providers care about their clients and may be frustrated by their attitudes and actions. In some cases, providers may have to "let go". The provider should not measure their success based on client actions, since these are not within the provider's control. Rather, the provider should measure success based on whether he/she helped the client to understand the importance of partner referral, the options available, and helped them develop a realistic partner referral plan.

PCRS is ongoing. It may be unrealistic for providers to assume they can solve all the issues surrounding effective PCRS in one session. For example, providers may feel pressure to "get all the names" right now. But PCRS need not be a single event. Follow-up sessions can be scheduled. It can also be helpful for providers to remember that the session is just one of many opportunities clients have to access their services and those of others. Providers should continue to support client referral and risk reduction plans during return visits.

PCRS Options

Recognizing that the client's participation is voluntary, the provider seeks to determine what might motivate the client to participate, and to help the client select appropriate referral options.

There are two basic approaches or options for reaching partners. **Client referral** is used when infected individuals choose to inform their partners themselves and refer those partners to counseling and testing. **Provider referral** is when the PCRS provider, with the consent of the infected client, takes the responsibility for contacting the partners and referring them to counseling, testing, and other support services. Sometimes a combination of the two approaches is used. With the **dual-referral** approach, the infected client informs the partner of his/her infection in the presence of the PCRS provider. By having a professional provider present, this approach supports the client and reduces other potential risks. With the **contract-referral** approach, the PCRS provider does the informing only if the client does not notify the partner within a negotiated time period. These four options are summarized in Table 2.

Client Referral

In the case of HIV infection, findings clearly indicate that fewer partners are actually informed of their possible exposure when the client-referral approach is used (versus Provider Referral). However, because PCRS is a voluntary process, clients should be able to choose this approach.

When clients choose to inform their partners themselves, they usually need some help to succeed. The provider should be prepared to assess the situation and the client's readiness and ability to succeed. Although most clients do not experience negative consequences when notifying partners, the provider can help the client minimize the potential for these consequences. For example, clients might need to be coached on (1) the best ways to inform each partner; (2) how to deal with the psychological and social impact of disclosing one's status to others, particularly in the case of HIV infection; (3) how to respond to a partner's reactions, including the possibility of personal violence; and (4) how and where each partner can access counseling, testing, and treatment. Partners may react by stating "You didn't get it from me" or "I feel fine". The client should be instructed, when speaking with partners, to (1) tell the partner the actual **name of the infection** the client has, (2) emphasize the importance of the partner seeking medical care **promptly**, even if they don't feel ill, and (3) emphasize the importance of the partner telling their doctor the **name of the infection** they were exposed to – partners should not make their doctor guess why they're seeking care or just ask for a "check-up" hoping to avoid embarrassment.

A disadvantage of Client Referral is that the client might unintentionally convey incorrect information about transmission, available support services, confidentiality protections, or other issues. Also, the client forfeits anonymity to partners, increasing the potential for disclosure of the client's infection status to third parties, subsequent discrimination, or partner repercussion. Despite its drawbacks, Client Referral is frequently chosen, and it can have some advantages. Because the client is usually more familiar with the identity and location of the partner, this approach can allow some partners to be referred for counseling and testing more promptly. Also, some clients choose this approach because they feel the best way to preserve a current relationship. Another obvious advantage is that when client referral is successful, fewer staff are used and fewer resources are consumed than with the provider-referral approach, so the financial burden for prevention programs is reduced.

Table 2 - Partner Referral Options

adapted from
Partner Counseling and Referral Services Guidance (CDC, December 1998) and
Partner Counseling and Referral Services Training Participant Manual (CDC, 2002, page H4-4, P4-7)

Options	Who notifies and refers the partners?	Does the provider "coach" the client?	Does the provider collect full exposure, identifying, and locating information about partners?	description	advantages	disadvantages
"Client Referral"	client	yes	no	The client informs partners that he/she has the STI and they may also have it. The client uses the name of the disease, and emphasizes that it is very important the partner sees a doctor promptly, even if they don't think they are infected. When speaking with partners, a caring attitude is helpful, while a blaming attitude is not. The counselor helps the client keep in mind that his/her partner, even if infected, may not know it. Some people may have some sexually transmitted infections for long periods without having symptoms.	-Client's familiarity with identity and location of partner can result in prompt referral. -Client preserves relationship with partner. Requires little in way of staff or resources.	-Client needs assistance. -Client lacks counseling skills and experience. -Client may unintentionally convey incorrect information about HIV transmission, available support services, confidentiality questions, etc. -Fewer partners are informed. -Client forfeits anonymity to partner. -Client may face embarrassment, shame, or even violence. -Potential for disclosure of serostatus to third parties, subsequent discrimination, or partner repercussion.
"Provider Referral"	provider	no	yes	With the client's permission, the provider informs the partner that someone with the disease has named them as a contact. This information is ideally shared face-to-face. The provider never discloses the client's name, but says only that a person who cares enough about them gave their name to ensure they receive appropriate care. The provider helps the partner access medical treatment and testing.	-Provider is able to verify that partners have been confidentially informed and have received client-centered counseling and testing in a timely fashion. -Provider ensures client's anonymity. -Well-trained provider helps defuse partner's potential anger and blame. -Results in greater numbers of partners informed than does Client Referral.	-Provider not always able to readily locate and identify partner. -Provider less familiar with lifestyles or problems of partner, therefore informing of exposure can be more difficult. -High cost.

Table 2 - Partner Referral Options

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Options	Who notifies and refers the partners?	Does the provider "coach" the client?	Does the provider collect full exposure, identifying, and locating information about partners?	description	advantages	disadvantages
"Dual Referral"	client discloses with provider present	yes	no	This option is generally used when the client's partner is in the waiting room. The dual referral involves the client's notifying the partner in the presence of the provider; the provider is then available to address partner concerns and questions. Under no circumstances should the provider notify the partner of the original client's infection status, because this would be a breach of confidentiality. The provider plans with the client for how the session may go and, if needed, coaches the client on what to say. This option supports the client and ensures the partner receives prompt and complete information and medical care.	-All the advantages of Client Referral, plus the provider can give immediate counseling, answer questions, allay concerns, refer partner to other services. -Client can notify partner in safe environment; provider's presence may temper partner reactions. -Provider can ensure that partner has been informed and counseled.	-Client requires coaching. -Client forfeits anonymity to partner. -Client loses intimacy when notifying (bringing stranger in). -Often little time for client or partner to prepare. -May set up an emotional triangle. -Provider often will not have established rapport with partner.
"Contract Referral"	client makes initial attempt; if unsuccessful, provider conducts referral	yes	yes	This is a negotiated agreement between the client and provider. The client agrees to inform the partner and, if that partner does not call or visit the provider a given date, then the provider notifies the partner.	-Depending on the situation, may include many of the advantages of a Provider Referral and/or a Client Referral, plus, the client has the option to back out of notifying partner, and partner will still be notified.	-Depending on the situation, may include many of the disadvantages of a Provider Referral and/or a Client Referral, plus, the provider and client must negotiate clearly to ensure partner is notified.

Provider Referral

When the client chooses provider referral, the provider will also need to assess the situation regarding each partner, including the best ways to inform them, how to locate and contact them, and how to respond to partners' reactions. Research indicates that provider referral is more effective in serving partners than client referral. Some of the advantages of using the Provider Referral approach:

-The provider is able to readily verify that partners have been confidentially informed and have received client-centered counseling, testing, and treatment.

-The provider can better protect the infected client's anonymity since no information about the client is disclosed to his or her partners.

-A well-trained provider is better able to defuse the partner's potential anger and blame reactions as well as accurately and more comprehensively respond to the partner's questions and concerns.

-Provider referral better facilitates learning about sexual networks, thus potentially enhancing overall STI prevention efforts in affected communities.

One disadvantage of the provider-referral approach is the fact that providers are not always able to locate partners. Since providers are less familiar with the partners, actually locating them can be more difficult than it might be for clients. The provider-referral approach may also entail substantial financial costs.

Regarding HIV infection, providers should keep in mind that some clients who choose provider referral might still notify some partners about their status and will thus need relevant counseling.

If the provider has an indication of a potentially violent situation for the client or others, the provider must make an assessment prior to notifying the partner and seek expert consultation before proceeding.

Two variations on provider and client referral are the Dual Referral and Contract Referral approaches. Potentially, combinations of these approaches can enhance the advantages of both approaches for the client while reducing the disadvantages.

Dual Referral

Some clients prefer to have the provider present when they inform their partner. This is an option that can be easily employed when the partner is in the waiting room. The dual approach allows the client to receive direct support in the notification process. The provider is in a position to provide immediate counseling, answer questions, address concerns, provide referrals to other services, and in some cases potentially minimize partner repercussions. Dual-referral enables the provider to know which partners have been served, and to some extent, learn about sexual networks. Whether the client or provider will take the lead in informing the partner should be worked out in advance of the notification. The provider still needs to coach and support the client as with the Client Referral approach. The provider and the client need to

consider, in particular, the partner's possible concerns about having his or her relationship with the client revealed to the provider. By considering this issue in advance, the client and the provider can anticipate the partner's possible reactions and discuss how to respond appropriately.

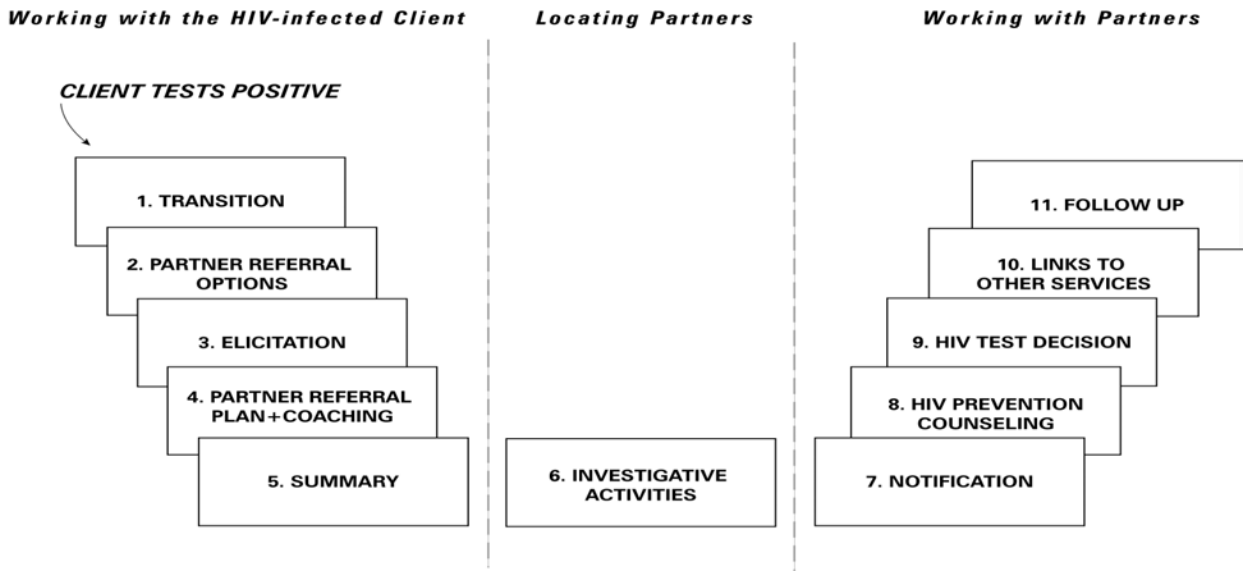
Contract Referral

This approach requires more negotiation skill on the provider's part and a relationship of trust between the provider and client. The provider and client decide on a time frame during which the client will contact and refer their partners. If the client is unable to complete the task within that agreed-upon time period, the provider then has the permission and information necessary to inform the partner. The provider must also have agreement with the client about how to confirm that partners were notified. For example, the provider should negotiate a provision with the client whereby the partner confirms in some way (e.g., telephone call, appointment for services) to the provider that he or she has been informed. Otherwise, the provider may have difficulty knowing which partners have been informed and whether or not provider referral or some other assistance is now needed.

PCRS Steps

The CDC describes a five-step process for working with HIV-infected infected clients. This model may be adapted to serve clients and partners infected and exposed to other STIs. These five steps do **not** necessarily occur in order. These steps are followed by investigation activities (step 6), and five additional steps involved in working with named partners (steps 7-11). These are shown in Figure 2.

Figure 2 – HIV PCRS Steps
from CDC 1999, PCRS Training Participant's Manual, page P1-9



Working with Clients

Step 1 – Transition.

PCRS rarely occurs as a single-purpose session. More often, clients are also receiving risk reduction counseling and may also be receiving testing and/or treatment in the same session. Client reactions vary significantly to learning about their STI, so the provider must gauge the appropriate point at which to initiate the discussion about the PCRS plan. In fact, other critical issues might need to be resolved first. For example, the client might express fear of a violent reaction from a partner. Resolving problems through role-playing, for example, might help clients overcome barriers to participating in PCRS and help them better prepare for their part in those activities.

Moving from discussions about treatment, testing, or personal risk reduction into the PCRS plan may occur at any opportune point during the session. A **transitional statement** is one way to redirect the conversation to a discussion of sexual partners. Some sample transitional phrases:

Figure 3 - Sample Transitions
Adapted from CDC 1999, PCRS Training Participant's Manual, handout 4-1

Let's talk a little about your partners, who probably are not aware of their risk, and how we can ensure that they're OK.

or

How do you feel about your partners being told they may have been exposed to (the STI)?

or

What are your feelings about telling your partners they may have been exposed to (the STI)?

or

What have you thought about your partners who need to know they've been exposed?

or

Now that we have talked about the various ways to keep you healthy, let's talk about ways we can keep your partners healthy. How do you feel about talking to your partners?

or

*As we discussed, the earlier people know if they have (*the STI*), the sooner they can see a doctor in case they are also infected. How would you feel about talking to your sexual partners who may also have this infection?*

or

*About how many people do you think you have had sex with in the past (*contract tracing period for the STI*)? Let's talk about them. How would you feel about telling me their names?*

Notice many of these questions elicit the client's feelings about PCRS, since knowing these can be helpful to the provider. If the client seems reluctant to discuss partners, the provider could ask some open-ended questions to determine what benefit the client perceives in helping their partners receive testing and treatment. The provider can then address those things that would motivate the client, such as benefits to themselves (avoiding re-infection), benefits to their partners, and benefits to the community.

Step 2 – Offer Options

In some cases infected clients initially will not want their partners notified. For example, they might fear loss of anonymity, the breakup of a relationship, or other adverse consequences. Clients might say that partners have already been informed about their risks or that partners would not be interested in counseling, testing, or other support services. Providers can encourage a client's participation by explaining that the partner benefits by knowing his or her infection status and being able to seek immediate treatment if infected. Also, if infected, the partner can avoid transmitting the infection to others. However, when a client is determined not to disclose partner names, the PCRS provider should counsel the client as if he or she has chosen the Client Referral approach. Describe the four options to the client, including the advantages and disadvantages (see Table 2). Then, check again on the client's feelings. Some of the client's concerns about their anonymity or other issues may have been assuaged by learning about the options. When describing the options, it is helpful to the client for the provider to also describe how the process works. Some sample scripts are included in Figure 4.

Figure 4 - Sample Script to Describe Referral Options
Adapted from CDC 1999, PCRS Training Participant's Manual, handout 4-3

One of the best ways to get help to your friends, ease your mind, and remain anonymous is to get in touch with your partners. Let me explain what I mean and what your partners would be told.

*I would make sure I have the right person, tell that person that I have something important to talk about, and ensure we were speaking privately. I would then tell the person that he or she has been exposed to (*the STI*). We would immediately provide your partner with the kind of counseling that you have received and offer him or her a chance to be tested.*

*I would not mention your name or anything about you that would tip your partner off to who gave us his or her name. I would not say anything about your gender, your physical description, your age, whether the exposure was sexual or through shared needles, the dates of the exposure or your location. This is the best way of notifying your partners when you want to remain anonymous. (*Provider Referral*)*

On the other hand, for the partners with whom you have an ongoing relationship that's important for you to maintain, you will probably want to tell them yourself. In this case, I can help you think through the best way to do this for each partner — and the best things to say. We could even practice a bit to build your confidence. (Client Referral)

I can also work with you so that you and I can tell a partner together. (Dual Referral)

If you try, but end up not being able to tell your partner, I'll get in touch with him or her. I would not mention your name or anything about you that would tip the partner off to who gave us his or her name. (Contract Referral)

You can pick a different way of handling each partner, depending on your relationship with that person. What questions or concerns do you have about any of these approaches?

Step 3 – Elicitation

Information to collect. In the elicitation step, the provider helps the client name all their partners during a discrete time period. For each partner you will gather information on:

-How the exposure occurred (sex or needle-sharing)
-How to locate the partner
-How to identify the partner

Motivate clients to participate in partner notification with timely and appropriate cues such as:

-mode of transmission
-confidentiality protection
-asymptomatic nature of diseases
-risk of reinfection
-social responsibility
-increased risk of acquiring and transmitting HIV if infected with another STD
-complications and consequences of untreated infections, including the impact on pregnancy and children

Helping clients remember and identify partners, you may need to use all your creative resources:

-Reassure clients of the ways in which their **confidentiality** will be protected
-Challenge conflicting information
-Address sensitive topics
-Encourage clients by helping them to consider the **benefits** — both to themselves and their partners — of participating in PCRS
-Stimulate clients memory through the use of existing tools, such as calendars, address books, diaries.

You will want to be client-centered when eliciting partner information. That means paying attention to the client's feelings and starting where they're willing to start. Some providers have found that it works best to create a fairly complete list of partners for the entire contract tracing period, before proceeding with collecting details about each. Some of the advantages of collecting all partners' names (or identifiers) before proceeding with detailed information on each include:

-Starting with a list of names, even just first names, can ease the client into giving more specific information later.

-The list of partners gives you a point of reference to help with coaching.

-Starting first with a list of names puts less pressure on the client to come up with a lot of details "on the spot."

-Creating a list of names may help jog the client's memory and gives the client some time to think of more specific details.

-Providing just names (and not other identifying information) makes him/her feel less threatened by the whole elicitation process.

In some cases, you may see disadvantages to starting with the full list of names. For example, if a client has had a lot of partners, she or he might not want to reveal that fact. Starting first with one name and accompanying information might be a more successful way to ease the client into the conversation. There is not a hard and fast rule about the order in which to work.

Collecting detailed exposure information is important to PCRS. It helps the provider set priorities among partners for notification — those most likely to be infected or to transmit. Collecting detailed location information helps investigators find partners more easily and helps them better maintain the partner's confidentiality (because they will go directly to the partner and not through intermediaries). Locating information may include home and work addresses and phone numbers, school attended, and hangouts.

Most of the identifying information needed may be elicited by asking a broad, open-ended question or polite imperative such as "*How would I know this person*?" or "*Describe this person to me*."

Step 4 – Partner Referral Plan and Coaching

The client will decide which options are best for each partner. For client's that elect the Client Referral, Dual Referral, or Contract Referral options, the provider will want to provide "coaching". The provider should assess the client's willingness and ability to:

-Contact partners promptly

-Find a private place for discussion

-Disclose their own STI status

-Help their partners understand the seriousness of the STI

-Accept that their partner is not bound to protect the client's confidentiality

-Refer the partner for services

-Anticipate and handle partner's reactions

Ask the client how soon they will speak with each partner, where they will meet, and what they will say. The provider should role-play as the client, while the client plays the role of the partner. This demonstration can help clients see a model notification and recognize whether or not they're ready to take on this responsibility. It also gives the provider a chance to see how the partner may react. As stated previously, the provider should demonstrate how the client could

(1) tell the partner the actual **name of the infection** the client has,
(2) emphasize the importance of the partner seeking medical care **promptly**, even if they don't feel ill, and
(3) emphasize the importance of the partner telling their doctor the **name of the infection** they were exposed to – partners should not make their doctor guess why they're seeking care or just ask for a "check-up" hoping to avoid embarrassment.

A fact sheet entitled How Do I Tell My Partner..?, designed to help clients understand the partner notification options and processes is included as an appendix to this document and is available on the website of the Navy Environmental Health Center (NEHC) Sexual Health and Responsibility Program (SHARP) at http://www-nehc.med.navy.mil/downloads/hp/contact.pdf.

Step 5 – Summarize

The summary step may have a significant influence of the ultimate success of the referral process. Important aspects of this step include:

-Review referral plans. Summarize the referral plan for each partner and check for agreement.

-Reemphasize confidentiality. Remind the client of how you will protect their identity.

-Ask client if he/she has any other questions.

-Offer your card and phone number. Leave the "door open" for them to return with any questions and requests for support.

-Transition back to the counseling session. Summarize any personal prevention plan made with the client, and give them condoms and appropriate brochures, etc.

Finding partners

Step 6 – Investigate

Navy providers will attempt to find, or request local Navy Preventive Medicine notification, of all named partners who (a) were exposed during the appropriate contact tracing period, (b) were included in the Provider Referral or Contract Referral plan of the client, (c) are DoD health care beneficiaries and (d) reside within the preventive medicine jurisdiction of the provider.

Locating and exposure information of **non-DoD healthcare beneficiary** partners will be reported to the cognizant public health authority. Although client information may also be reported to local or state health authorities, providers are reminded that these reporting systems are separate and that the name of the original client is never linked to the partner in such reports. Providers should follow local guidance for local reporting of partners. This may entail locally-designated forms and procedures. For partners located outside the local area, partner identification information may be sent to the State public health authority (who will forward the report to the cognizant State or local health authority) using a State-specific form and process or

using CDC Form 73.2936S - Field Record (a sample of this form is included as an appendix). Providers should not expect confirmation of receipt or a disposition report. If a disposition report is desired, the provider should so state on the Field Record, and provide a statement of justification and return address/phone information. Providers are encouraged to be familiar with the addresses, phone numbers, forms, and processes for the local or state in which they are located.

Locating and exposure information of **DoD healthcare beneficiary** partners will be reported to the cognizant local military public health authority using any locally (i.e. Preventive Medicine) approved form or CDC Form 73.2936S - Field Record. Providers may receive telephone numbers and mailing addresses for local military public health and preventive medicine offices from:

-Army: Center for Health Promotion and Preventive Medicine, (Aberdeen Proving Ground, MD), **(**410) 436-4312 [DSN 584]

-Air Force: HQ Air Force Medical Operations Agency, Public Health (Bolling AFB, Washington D.C.), (202) 767-1839 [DSN 297]

-Navy: Environmental Health Center, Directorate of Population Health (Portsmouth. VA.), (757) 953-0700 [DSN 377]

Working with Partners

Step 7 – Notification

Notifying partners can be challenging. Providers may be concerned about informing the right person, how the partner may react, preventing adverse consequences to the original client, and avoiding breeches of confidentiality, among other issues. It may be helpful to providers to know that, in a study in South Carolina (Jones et al 1990, page R-54), most partners notified felt the health department did the right thing in telling them (87%) and felt the health department should continue to notify people exposed to HIV (92%). When the notification is handled professionally, named partners often respond positively to the notification and seek medical evaluation.

Providers are encouraged to keep a record of their attempts to notify partners. This record should document each phone call and include a file copy of any partner notification form sent to another public health agency. This record may be important later if a coworker tries to notify the partner, for reviewing what past attempts have failed, to explain your efforts to program evaluators, to answer any concerns that clients or partners may raise, and to demonstrate a good faith effort to find partners. Providers are encouraged to seek local (i.e. Preventive Medicine) guidance for specific documentation requirements or policies, if any. As previously mentioned, to preserve patient privacy, records of PCRS activities should be destroyed when no longer needed.

As previously mentioned, spouses of HIV-infected military reservists must be notified in accordance with SECNAVINST 5300.30C (paragraph 12c). Other partners of HIV-infected clients should be notified face-to face if at all possible.

Two important issues for partner notification are:

(1) Make sure you have the right person
(2) Protect the confidentiality of the original client

When notifying partners by telephone, first ensure you have the right person. Then, ask to ensure you are speaking privately (not on speaker phone or in busy place where they cannot speak privately). Ask the partner to come in to your office to discuss a personal medical issue and arrange an appointment or meeting. If the partner insists on first knowing the purpose of the appointment, the provider may inform the partner over the phone. Otherwise, face-to-face notification is preferred. As previously mentioned, providers should not reveal to others why they are trying to find a particular person. Likewise, providers should never leave a note or message that mentions an STI exposure as the reason for attempting to make contact.

Sample scripts of notification conversations are offered in Figure 5.

Figure 5 - Sample Script to Notify and Respond to Partners

*Hello. Am I speaking with (*partner name*)? Are you the same (*partner name*) that (works at __, or is assigned to ___?* - insert identifying details that will confirm you have the right person but will not link the client to the partner)

*I'm (*HM2 Smith*) from (*Naval medical facility*). Are we speaking privately? I'd like to speak with you about a personal medical matter. Can you come in to see me? It's not an emergency, but I would like to speak with you soon. I think it would be best if we spoke about this in person. Is that alright with you?*

You have been named as a sexual partner of a person who has been diagnosed with (infection name*). It's important you receive (*the recommended testing and/or treatment*) to ensure that you're OK.*

In response to that partner's statement "I feel fine" or other denial of the need for testing/treatment – *Some people who have this infection are completely unaware of it. But the infection can cause health problems if untreated and the infection may also be spread to other people. It's important that anyone who may have been exposed to this infection receives prompt (*appropriate testing and/or treatment*).*

If asked "Who gave you my name" – *I'm obligated to protect the privacy of every patient. I can tell you that the person who told us about you was a person who cares enough about you to make sure you're OK.*

Step 8 - Counseling

The partner notification event provides an opportunity for providers to assess the partner's sexual risk behavior and to help the partner reduce future risks. Sample scripts for this process are found in Figure 6.

Provider training in client-centered prevention counseling and in sexual risk assessment skills is available. Details are included later in this document.

Figure 6 - Sample Script to Assess and Respond to Risk Behavior

How many people have you had sex with over the past 6 months or so?

*What is the riskiest thing you're doing in your life that could expose you to (*the infection*) or to HIV or an unplanned pregnancy?*

*What have you done in the past to protect yourself from (*the infection*) or HIV or an unplanned pregnancy?*

What would you like to do in the future to protect yourself? Note: to help the partner understand their options, see the attached SHARPFact fact sheet entitled "Choosing safer Options Reduces Risk"

*What do you see as the advantages to doing (*the safer behavior the partner wants to adopt*)?*

*What will be the hardest thing about doing (*the safer behavior the partner wants to adopt*)?*

How will you incorporate this plan into your life?

Step 9 – HIV Test Decision

HIV testing should be offered to all named sexual partners. Testing under these circumstances is the option of the named partner. Providers are reminded to complete the locally-approved informed consent form for any HIV testing of non-active duty members.

When offering the test, providers are encouraged to determine if there are any local or state guidelines or laws for pre or post-test HIV counseling.

The provider should explain the HIV test and the meaning of a negative and positive result, and how the partner will be informed of the test results.

Step 10 – Link to Other Services

Partners may need to be referred to other professionals to complete the PCRS process or to support some other identified need.

For example, the provider may need to arrange testing and/or treatment. Providers are strongly encouraged to make these arrangements while the partner is in their office – and it is certainly preferable to provide these services in the same building and during the same visit if possible. This "one-stop" or comprehensive service setting inhibits losing partners to follow-up and minimizes patient/customer inconvenience. PCRS providers who do not have working space in the same building where testing and treatment services are offered operate at a disadvantage and are encouraged to reconsider their operating location.

Partners may also express a desire for access to other services, such a those of the chaplain or family service. These referrals, and the personal issues involved, may be very important to the ultimate success or failure of PCRS and risk reduction. Again, providers are strongly encouraged to make these arrangements while the partner is in their office.

Step 11 – Follow-up

The provider should check to ensure the partner completed the agreed-upon referrals for testing, treatment, and other services and seek to assist the partner where needed. Providers are encouraged to ask partners (and clients) for their permission to follow-up or "check in to see how things are going".

Figure 7 – Coordination With Public Health Authorities

These are some questions a PCRS provider might ask of their cognizant Preventive Medicine Officer and local and state public health authorities:

-HIV and STD control program contact information (names, phone, address, fax, e-mail)

-Reportable disease program contact information and process

-Partner notification processes:
- Which exposures will be followed-up by them, which will not?
- What is the partner reporting process? (local forms, phone calls, etc.)

-Local and state laws affecting:
- PCRS activity record keeping
- HIV spouse notification – Other obligatory notifications
- "duty to warn"
- Reporting violence /threats of violence
- Reporting child abuse

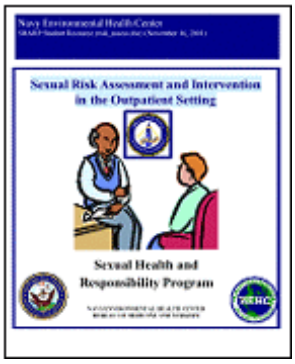
Providers should always consult their medicolegal advisor regarding the applicability of local and state laws to Navy medical operations.

Provider Training

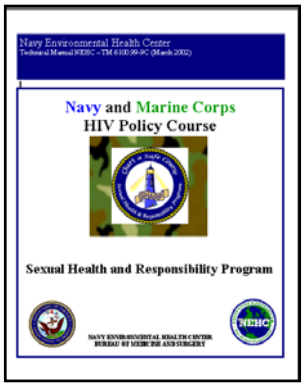
Of all the resources necessary for the successful operation of PCRS programs, training is perhaps the most critical. Among CDC recommendations are that each provider receive initial basic training plus periodic updates on how to conduct PCRS, provide client-centered counseling, protect individuals' rights to privacy, use scientific information in prioritizing partners, and defuse potentially violent situations involving clients, partners or staff, and understanding laws regarding confidentiality of medical records.

Detailed information about the following **SHARP training** courses is available on the internet at http://www-nehc.med.navy.mil/hp/sharp/index.htm).

Fundamentals of HIV-STD Prevention Counseling is a 2-day course for physicians, nurse practitioners, physician assistants, clinical and DoDDS school nurses, Preventive Medicine Officers and Technicians, Environmental Health Officers, Independent Duty Corpsmen, health promoters, and family service counselors – people tasked to counsel individual Sailors and Marines regarding sexual behavioral risk reduction. This course is based on Project RESPECT, a study which meets CDC's HIV/AIDS Prevention Research Synthesis project criteria for relevance and methodological rigor and also has positive and significant behavioral/health findings. Continuing education credit is awarded.



Sexual Risk Assessment in the Outpatient Setting is a fully scripted PowerPoint presentation and demonstration that includes a student manual. The lecture targets health care providers including IDCs. It may be used an in-service training session within medical treatment facilities or as a self-study course. The objective is to demonstrate the need for and the skills used in conducting a sexual behavior risk assessment during the routine out-patient encounter. Typical length of the lecture is 60-90 minutes. Continuing Education Credit is awarded. Download the PowerPoint presentation and the student manual to conduct this training lecture at your locale.



Navy and Marine Corps HIV Policy is a self-study course that explains DoD and DoN policy regarding HIV. This course is available on the SHARP web site. SHARP issues a certificate of training to each person who completes the 38-question exam. Continuing education credit is awarded.

SHARP's Sexual Health Primer is a self-study course which covers the impact of STDs and unplanned pregnancy, Risk Assessment and Risk Reduction Counseling – Guidance and Training for Health Care Providers, "SHARP Facts" Fact Sheets on STDs; unplanned pregnancy; HIV testing; options for risk reduction; male and female condoms; talking to teens about sexual responsibility; and family planning. This course is available on the SHARP website. SHARP issues a certificate of training to each person who completes the 40-question exam. Continuing education credit is awarded.

SHARP's "HIV-AIDS Facts Quiz" is a resource and self-study course for health care professionals. These registered SHARP instructors receive a copy of the American Red Cross ***Facts Book*** to help them answer, in a culturally sensitive, non-judgmental way, the HIV-AIDS questions people in their community are likely to ask. SHARP issues a certificate of training to each person who completes the 50-question quiz. Continuing education credit is awarded.

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SHARP Sexual Partner Counseling and Referral Examination

1) The purpose of PCRS is to
   a) Get all the names of sexual contacts
   b) Determine if any laws have been broken
   c) Alert people exposed to sexually transmitted infections (STI) and facilitate appropriate counseling, testing, and treatment
   d) None of the above

2) PCRS is often accompanied by
   a) Risk-reduction counseling
   b) Core-values training
   c) Religious instruction
   d) Criminal investigation

3) An effective strategy for gaining a great deal of information in a short time, for uncovering relevant feelings, issues, and circumstances, and for engaging the client in the conversation is the use of
   a) A checklist
   b) A patient brochure
   c) Open-ended questions
   d) Closed-ended questions

4) Studies have shown that providers can be effective even if they are not of the same gender as the client
   a) True
   b) False

5) The decision about which partners should be notified depends upon
   a) The STI
   b) The client's sexual history
   c) The likelihood of the partner being notified
   d) All the above

6) Two conditions that should be considered when prioritizing the investment of healthcare resources in partner notification efforts include
   a) The quality of the information about the partner
   b) The policies and practices of the cognizant public health authority
   c) Both a and b
   d) Neither a nor b

7) Which partners of a client diagnosed with gonorrhea should be notified of their exposure?
   a) All named sexual partners and the spouse even if not named
   b) All named or suspected sexual partners
   c) All named sexual partners within the 60 days preceding the onset of symptoms or the most recent partner if >60 days
   d) None of the above

8) For clients diagnosed with Hepatitis C, which partners should be informed of the low but present risk of transmission?
   a) All partners during the past 10 years
   b) All partners during the past 1 year
   c) All partners within the past 14 days
   d) Long-term steady partner(s)

9) For partners of clients diagnosed with genital warts
   a) Notification is not necessary
   b) Clients may consider informing their partners since their partners may benefit from an examination
   c) Both a and b
   d) Neither a nor b

10) Which of the following statements are true?
   a) No person can be forced to disclose the names of his/her partners
   b) PCRS relies on the willing participation of the client and their partners
   c) Both a and b
   d) Neither a nor b

11) The counseling concept that is helpful for uncovering underlying feelings and motivations is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

12) The counseling concept that recognizes that the provider and client enter the interaction with their own set of values, biases, and beliefs is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

13) The counseling concept that based on the fact that providers must acknowledge that clients may not choose the referral options and plans the provider would prefer is called
   a) Focus on feelings
   b) Manage your own discomfort
   c) Set boundaries
   d) None of the above

14) The two basic approaches or options for reaching partners are "client referral" and "provider referral"
   a) True
   b) False

15) Who chooses the referral option to be used?
   a) The provider
   b) The client
   c) The partner
   d) None of the above

16) A different referral option may be chosen for different partners of the same client
   a) True
   b) False

17) The referral option(s) that enable the client to remain anonymous is/are
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) None of the above

18) For Client Referrals, the provider should discuss with the client
   a) How to deal with the psychological and social impact of disclosing one's status to others, particularly in the case of HIV infection
   b) How to respond to a partner's reactions, including the possibility of personal violence
   c) How and where partners may access counseling, testing, and treatment
   d) All the above

19) For Client Referrals, the provider should instruct the client, when notifying his/her partner, to
   a) The infected client should tell the partner that the client has the infection and that the partner may also have it
   b) The client should state actual name of the infection they have
   c) The partner should see a doctor promptly, even if the partner does not feel ill, and tell the doctor the name of the infection they were exposed to
   d) All the above

20) Among the advantages of Client Referral are
   a) The client's familiarity with the partner can result is prompt referral
   b) The client may consider self-disclosure the best way of maintaining the relationship
   c) This option requires little in terms of provider staff resources
   d) All the above

21) One of the advantages of Provider Referral is that the client's anonymity is preserved
   a) True
   b) False

22) A disadvantage of Provider Referral is
   a) Provider is not always able to locate the partner
   b) High cost
   c) Both a and b
   d) Neither a nor b

23) The option generally used when the partner is in the waiting room is called
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

24) The option which gives the client an opportunity to notify the partner within an agreed upon time frame with the provider initiating notification after that period is called
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

25) This referral option includes many of the advantages of Provider Referral and/or Client Referral, plus the client has the option to back out of notifying the partner, yet the partner will still be notified
   a) Client Referral
   b) Provider Referral
   c) Dual Referral
   d) Contract Referral

26) Moving from discussions about treatment, testing, or personal risk reduction into the PCRS plan may occur at any opportune point during the session. One way to redirect the conversation to a discussion of sexual partners is known as
   a) Transitional statement
   b) Shock therapy
   c) Investigation
   d) None of the above

27) In the elicitation step, the provider helps the client name all their partners from a discrete time period. For each partner you will gather information on
   a) How exposure occurred (sex or needle-sharing)
   b) How to locate the partner
   c) How to identify the partner
   d) All the above

28) When eliciting partner information, providers should
   a) Reassure clients of the ways in which their confidentiality will be protected
   b) Challenge conflicting information
   c) Encourage participation by reminding clients of the benefits
   d) All the above

29) Some providers collect all partners' first names (or identifiers) before proceeding with detailed information. An advantage(s) of this strategy is/are
   a) Starting first with a list of names puts less pressure on the client to come up with a lot of details "on the spot"
   b) Creating a list of names may help jog the client's memory and gives him or her some time to think of more specific details
   c) Providing just names (and not other identifying information) makes the client feel less threatened by the whole elicitation process
   d) All the above

30) A rule of thumb for partner notification is
   a) Make sure you have the right person
   b) Protect the confidentiality of the original client
   c) Both a and b
   d) Neither a nor b

31) The process of informing people that they have been named as partners is an opportunity to assess their sexual risk behavior and help them reduce future risk
   a) True
   b) False

32) HIV testing is mandatory for named partners of people who have an STI
   a) True
   b) False

33) Providers are strongly encouraged to make follow-up arrangements while the partner is in their office
   a) True
   b) False

End of Examination

Answer Sheet and Course Critique
SHARP Sexual Partner Counseling and Referral

Send by post, fax, or e-mail to
Navy Environmental Health Center-HP-SHARP
620 John Paul Jones Circle, Suite 1100, Portsmouth VA 23708-2103
fax: (757) 953-0688 [DSN 377]
e-mail macdonaldb@nehc.med.navy.mil

Name (as desired on the certificate) _____
Rank: _____ Date _____ Professional Affiliation _____
Number of hours spent completing the course and examination: _____
SSAN or license # (for CEU/CME) _____
Duty mailing address _____
_____
_____
_____
Duty telephone: _____Duty e-mail: _____

My assessment of the course and **achievement of the learning objectives:**
("x" the appropriate boxes):

	Not Helpful	Helpful	Very Helpful
PCRS purpose			
Contact tracing periods			
PCRS concepts			
PCRS options			
PCRS steps			

Comments (continue on reverse):

-Answers:

1.	10.	19.	28.
2.	11.	20.	29.
3.	12.	21.	30.
4.	13.	22.	31.
5.	14.	23.	32.
6.	15.	24.	33.
7.	16.	25.	
8.	17.	26.	
9.	18.	27.	

(Completion of this standard form is required for students applying for **AMA** continuing education credit, such as physicians and physician assistants)

CME ACTIVITY EVALUATION

SHARP self-study course
"Sexual Partner Counseling and Referral – Information for Navy Healthcare Providers"

Date: _____

I. Please evaluate this educational activity as a whole by checking the appropriate box, below:

OVERALL EVALUATION						
	Excellent	**Very Good**	**Good**	**Fair**	**Poor**	**N/A**
Usefulness						
Quality						
Facilities/Management						X
Registration						
Environment						
Audiovisuals						
Food & Beverage						X

II. Course Objectives: Were the following course objectives met?

Course Objective	Yes	No
The student will be able to **identify** and **discuss** basic facts concerning PCRS purpose, Contact tracing periods, PCRS concepts, PCRS options and PCRS steps.		

III. General Comments

A. Do you feel the program was fair, balanced, and free from commercial bias?
YES NO
If NO, please state reasons: _____

_____

B. Suggested topics and/or speakers you would like for future programs:

_____

_____

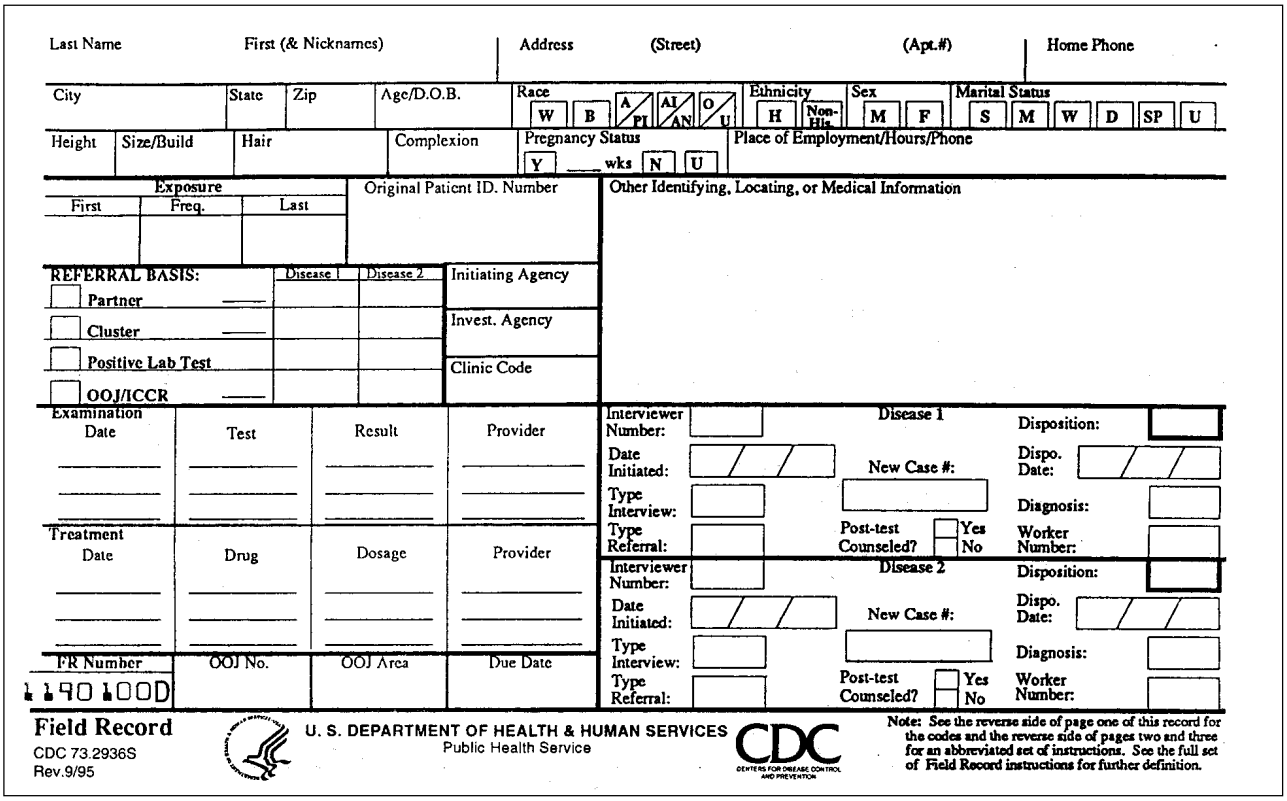
_____

C. Did the presenters provide verbal disclosure? YES NO

D. Did presenters provide information regarding unapproved/off-label use of products? YES NO

E. This Educational activity has contributed to my professional effectiveness and improved my ability to:

	Strongly agree				Strongly disagree
• Treat/manage patients	1	2	3	4	5
• Communicate with patients	1	2	3	4	5
• Manage my medical practice	1	2	3	4	5
• Other:	1	2	3	4	5



Last Name | First (& Nicknames) | Address (Street) (Apt.#) | Home Phone

City | State | Zip | Age/D.O.B. | Race (W B A/PI AI/AN O/U) | Ethnicity (H Non-His) | Sex (M F) | Marital Status (S M W D SP U)

Height | Size/Build | Hair | Complexion | Pregnancy Status (Y ___ wks N U) | Place of Employment/Hours/Phone

Exposure: First | Freq. | Last

Original Patient ID. Number

Other Identifying, Locating, or Medical Information

REFERRAL BASIS: | Disease 1 | Disease 2 | Initiating Agency
- Partner ___
- Cluster ___
- Positive Lab Test
- OOJ/ICCR ___

Invest. Agency

Clinic Code

Examination: Date | Test | Result | Provider

Treatment: Date | Drug | Dosage | Provider

FR Number 1190100D | OOJ No. | OOJ Area | Due Date

Interviewer Number:
Date Initiated:
Type Interview:
Type Referral:
Disease 1
New Case #:
Post-test Counseled? Yes No
Disposition:
Dispo. Date:
Diagnosis:
Worker Number:

Interviewer Number:
Date Initiated:
Type Interview:
Type Referral:
Disease 2
New Case #:
Post-test Counseled? Yes No
Disposition:
Dispo. Date:
Diagnosis:
Worker Number:

Field Record
CDC 73.2936S
Rev.9/95

U. S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Note: See the reverse side of page one of this record for the codes and the reverse side of pages two and three for an abbreviated set of instructions. See the full set of Field Record instructions for further definition.

Field Record Codes

Disease/Diagnosis Codes

- **100** - Chancroid
- **200** - Chlamydia
- **300** - Gonorrhea (uncomplicated)
- **350** - Resistant Gonorrhea
- **400** - Non-Gonococcal Urethritis
- **450** - Mucopurulent Cervicitis
- **490** - Pelvic Inflammatory Disease (Syndrome)
- **500** - Granuloma Inguinale
- **600** - Lymphogranuloma Venereum
- **700** - Syphilis Reactor
- **710** - Primary Syphilis
- **720** - Secondary Syphilis
- **730** - Early Latent Syphilis
- **740** - Latent Syphilis, Unknown Duration
- **745** - Late Latent Syphilis
- **750** - Late Syphilis with Symptomatic Manifestations
- **760** - Neurosyphilis
- **790** - Congenital Syphilis
- **800** - Genital Warts
- **850** - Herpes
- **900** - HIV
- **950** - AIDS (Syndrome)

STD Disposition Codes

- **A** - Preventive Treatment
- **B** - Refused Preventive Treatment
- **C** - Infected, Brought to Treatment
- **D** - Infected, Not Treated
- **E** - Previously Treated for This Infection
- **F** - Not Infected
- **G** - Insufficient Information to Begin Investigation
- **H** - Unable To Locate
- **J** - Located, Refused Examination
- **K** - Out Of Jurisdiction
- **L** - Other

HIV Disposition Codes

- **1** - Previous Positive
- **2** - Previous Negative, New Positive
- **3** - Previous Negative, Still Negative
- **4** - Previous Negative, Not Re-tested
- **5** - Not Previously Tested, New Positive
- **6** - Not Previously Tested, New Negative
- **7** - Not Previously Tested, Not Tested Now
- **G** - Insufficient Information to Begin Investigation
- **H** - Unable To Locate
- **J** - Located, Refused Counseling and Testing
- **K** - Out Of Jurisdiction
- **L** - Other

Partner Codes

- **P1** - Sex Partner
- **P2** - Needlesharing Partner
- **P3** - Both Sex and Needle

Cluster Codes

- **S1** - Suspect 1
- **S2** - Suspect 2
- **S3** - Suspect 3
- **A1** - Associate 1
- **A2** - Associate 2
- **A3** - Associate 3

Type Interview

- **O** - Original Interview
- **R** - Reinterview
- **C** - Cluster Interview
- **P** - Posttest Counseling
- **U** - Unable to Interview (But Partners/Clusters are Initiated)

OOJ/ICCR Codes

1 - Partner **2** - Cluster **3** - Positive Test

Type Referral

1 - Patient **2** - Provider

SHARP FACTS
How do I tell my partner…?

Why should my sexual partner be told that I have a sexually transmitted disease?

If you have a sexually transmitted disease, any or all of the people you had sex with (vaginal, oral, or anal sex) may also be infected with the disease. But they may not even know they are infected. By notifying them, you can help ensure they receive the medical treatment they need. Telling your partner shows you respect and care about them. Your honesty may build trust and may encourage your partner to share sexual health information with you. Telling your partner may also prevent future misunderstandings or legal action. Many people who are infected with an STD do not notice any symptoms, until they become very ill. For example, while most (though not all) men who are infected with Chlamydia or gonorrhea get symptoms within 30 days of becoming infected, most women do not. Instead, many women may not notice their infection at all, until it causes very serious problems, like pelvic inflammatory disease (PID) or infertility. It is very important that everyone who may have been exposed to the disease gets treated. This protects people from the sometimes very serious consequences of untreated infections, and it protects their sexual partners (like you) from getting their infection.

Which of my partners need to know about this?

For each disease, there is a recommended contact tracing period. Anyone you have had sex with during the contact tracing period should be told that they might have been exposed. Some contact tracing periods are:

Chancroid	10 days
Chlamydia	60 days (or most recent partner if >60 days)
Genital Herpes	current sex partners
Gonorrhea	60 days (or most recent partner if >60 days)
Granuloma Inguinale	60 days
Hepatitis B, acute	within 14 days after the most recent sexual contact
Hepatitis B, chronic	No contact time period specified. Minimally, current sexual partners, needle-sharing partners and non-sexual household contacts should be offered hepatitis B vaccine.
Hepatitis C	Long-term, steady sex partners should be informed of the low but present risk of transmission and be offered counseling and testing.
HIV	Back to 6 months before last negative HIV test for people who have tested negative in the past. Or, one year back is a short enough period to have the greatest impact on disease transmission with most-recently-exposed partners, including current and steady partners. Some people may have a sense of when they became infected or for some other reason may be concerned about partners from further back than one year. Spouses: SECNACVINST 5300.30C requires that spouses of HIV positive military reservists be provided notification, counseling, and testing.
Human Papillomavirus (genital warts)	"Examination of sex partners is not necessary…" although "…sex partners…may benefit from examination to assess the presence of genital warts and other STDs." "Female sex partners of patients who have genital warts should be reminded that cytologic screening for cervical cancer is recommended for all sexually active women". (see page 56 of MMWR 51;RR-6, 10 May 2002)
PID	60 days
Pubic lice	one month
Lymphogranuloma Venereum	30 days
Nongonococcal Urethritis	60 days
Scabies	one month
Syphilis, primary	3 months, plus duration of symptoms
Syphilis, secondary	6 months, plus duration of symptoms
Syphilis, early latent	1 year
Trichomoniasis	"sex partners should be treated"

SHARP FACTS

How do I tell my partner…?

Ensuring medical treatment for everyone exposed is the right thing to do.

Everyone benefits from the elimination of sexually transmitted infections. Your partner is treated, you are protected from re-infection if you have sex with them again (assuming they are also treated), you receive the satisfaction of knowing you have acted responsibly, and the disease burden and potential sources of infection are reduced in the community.

What does my partner need to know?

- the name of the disease they may have, or may have been exposed to,
- the importance of seeing a doctor even if they have no symptoms of the disease,
- the importance of telling the doctor the name of the disease they may have,
  (They should **not** make the doctor guess why they are there. They should **not** just ask for a "check-up")
- the importance of acting promptly, since they may have had the infection for some time.

How can my partners be given the information they need?

There are a few ways to go about this. You might choose a different approach for each of partner, depending on your relationships and what you feel will work best for you and for them. Your health care professional will discuss each of these with you and help you formulate a plan.

- Option 1, "Client referral". You inform your partner that you have the disease and they may also have it. Use the name of the disease, and emphasize that it is very important they see a doctor promptly, even if they don't think they are infected. When speaking with your partner, a caring attitude is helpful, while a blaming attitude is not. Keep in mind that your partner, even if infected, may not know it. Some people may have some sexually transmitted infections for long periods without having symptoms.
- Option 2, "Provider Referral". With your permission, a trained health care professional informs your partner that someone with the disease has named them as a contact. This information is ideally shared face-to-face. The health care worker never discloses your name, but says only that a person who cares enough about them gave their name to ensure they receive appropriate care. The health care worker then helps your partner access medical treatment and testing.
- Option 3, "Dual Referral". You inform your partner in the presence of the health care professional. This approach supports you and ensures your partner receives prompt and complete information and medical care.
- Option 4, "Contract Referral". This is really Options 1 and 2 combined. You agree to inform you partner and, if that partner does not call or visit the health care professional by a given date, then the health care professional informs your partner and arranges treatment and testing.

Where can I get more information?

A health care provider should be consulted if you suspect you have a sexually transmitted disease. Your local health care provider or preventive medicine office can help you with the notification of your sexual contacts if you do have a sexually transmitted disease. CDC provides information through their National STD Hotline at (800) 227-8922. For further information regarding your sexual health, visit the Sexual Health and Responsibility Program Home Page at http://www-nehc.med.navy.mil/hp/sharp.

This information was adapted by the Sexual Health and Responsibility Program (SHARP), Directorate of Health Promotion and Population Health, Navy Environmental Health Center, from material developed by the National Center for HIV, STD and TB Prevention, Centers for Disease Prevention and Control, Partner Counseling and Referral Services Guidance (December 1998) and STD Guidelines for Treatment of STDs 2002 (MMWR 51;RR-6, May 10, 2002).

SHARP FACTS

Choosing Safer Options Reduces Risk

Introduction

Nearly 1 million Americans are infected with HIV, most of them through sexual transmission. As many as one-third of these people don't even know they are infected. One in three cases of HIV infection in the U.S. now occurs in a women. About half of all infected women and some infected men were infected by heterosexual contact.[1] HIV is spread between men and women. In fact, women in the U.S. and around the world are becoming increasingly affected by HIV. Approximately 46%, or 14.8 million, of the 32.4 million adults living with HIV or AIDS worldwide are women. An estimated 15.3 million new sexually transmitted infections, including HIV, occur each year in the United States. Experts estimate that one in four Americans will become infected with a sexually transmitted disease in their lifetime. Effective strategies for preventing these diseases are critical.

How can we reduce our risk of getting one of these diseases? What are the options?

Abstain from sex or delay sex

Refraining from having sexual intercourse with an infected partner is the best way to prevent transmission of HIV and other STDs. People can choose to not have sex. People can also decide to wait, or delay sex, until a later time in their life. They may choose to have personal relationships that do not involve sex.

Choose Outer-course vs. Intercourse

Outer-course is non-penetrative contact, such as massaging, hugging, and kissing. Non-penetrative contact vs. intercourse can eliminate transmission risk for HIV and most (though not all) STDs.

But, if you choose to have sex, there are things you can do to reduce the risk of acquiring a sexually transmitted disease, including HIV:

Monogamy

Monogamy is sex between two people, who only have sex with each other, as part of a long-term relationship. If neither partner is infected, there is no risk of disease transmission. Getting to know your partner and his/her sexual history before you decide to have sex can also reduce your chance of exposure to disease. A series of short-term relationships is not as safe because of the increased risk that one of those partners will be infected.

Use Condoms and other barriers

Although not as safe as abstinence or monogamy, the correct and consistent use of latex condoms during sexual intercourse - vaginal, anal, or oral - can greatly reduce a person's risk of acquiring or transmitting many STDs, including HIV infection. In fact, recent studies provide compelling evidence that latex condoms are highly effective in protecting against HIV infection when used for every act of intercourse. A variety of male condoms are available. Female condoms and oral barriers are also available. Condoms can reduce both the risk of pregnancy and the risk of disease transmission. Put the condom on before any vaginal, anal, or oral contact.

Condoms can be expected to provide different levels of risk reduction for different STDs. There is no one definitive study about condom effectiveness for all STDs. Several studies have demonstrated that condoms can reduce the risk of acquiring chlamydia, gonorrhea, trichomoniasis, syphilis, chancroid and herpes. However, because not all studies have demonstrated protective effects, the body of evidence is considered inconclusive. In addition, definitive data are lacking regarding the degree of risk reduction that latex condoms provide in preventing transmission of genital Humanpapilloma Virus. It is important to note that the lack of data about the level of condom effectiveness indicates that more research is needed – not that latex condoms don't work.

Plastic Condoms. Studies show that the new polyurethane condoms have the same barrier qualities as latex. Lab testing has shown that particles as small as sperm and HIV cannot pass through this polyurethane material. A study of the effectiveness of this polyurethane condom for prevention of pregnancy and STDs is underway. The

new polyurethane condoms offer an alternative for condom users who are allergic to latex. Also, polyurethane condoms can be made thinner than latex, have no odor, and are safe for use with oil-based lubricants.

Condoms for Women. The "Reality" female condom™, also made of polyurethane, is lubricated and disposable. The lubricant is non-spermicidal. One study of this condom as a contraceptive indicates a failure rate of 21-26 percent in 1 year among typical users; for those who use the female condom correctly and consistently, the rate was approximately 5 percent. Unlike the male condom, the female condom™ protects the external female genitalia because its outer edge remains outside the vagina during sex – resulting in less skin-to-skin contact. If a male condom cannot, or will not be used, consider using a female condom.

Reduce the number of sexual partners

Many people who are infected with an STD don't know it, and you can't tell just by looking at them. The more people a person has sex with, the more likely it is that one (or more) will be infected with an STD. Though not as safe as abstinence or monogamy, reducing the number of people a person has sex with can reduce risk by reducing the number of potential exposures.

Do not have sex with "high-risk" people

You can't tell if potential partners are "high risk" just by looking at them. People who may be at higher risk of having a sexually transmitted infection include those who trade sex for money or sex for drugs, because they may have sex with many other people. Other people who may be at higher risk are people who share needles, because this activity can result in HIV, Hepatitis B and Hepatitis C infections, which can then be spread sexually. Non-monogamous men who have sex with men are also at higher risk of being infected with HIV and Hepatitis B because the risk of transmitting these viruses is greater with receptive anal intercourse than with vaginal or oral intercourse, and because these men may have many sex partners. Though not as safe as abstinence or monogamy, avoiding sex with "high-risk" people can reduce risk of exposure to a sexually transmitted infection.

Other things that can reduce the risk of infection with HIV or other STDs are:

Do not share needles or "works"

The safest thing a person can do is to not inject (non-prescription) drugs. For people who do continue to inject drugs, use a new, sterile needle from a reliable source each time. HIV and other viruses can be spread whenever needles are contaminated with blood - even small quantities of blood which may not be visible to the naked eye. This is true of all needles – including needles used for steroids, tattooing or body piercing. If sterile needles cannot be used, disinfect needles and syringes before and after each use.

Stay sober

Use of drugs or alcohol can affect sexual behavior because of reduced inhibitions and clouded judgment. Stay in control – stay sober.

Where can I get more information?

Your medical care provider should be consulted if you think you may have been exposed to any sexually transmitted disease. CDC provides information through their National STD Hotline at (800) 227-8922 and their National AIDS Hotline at (800) 342-AIDS (2437). For further information regarding your sexual health, visit the SHARP Home Page at http://www-nehc.med.navy.mil/hp/sharp.

This information was adapted by the Sexual Health and Responsibility Program (SHARP), Directorate of Health Promotion and Population Health, Navy Environmental Health Center, Norfolk Virginia, from material developed by the Centers for Disease Control and Prevention, National Center for HIV, STD & TB Prevention, Division of HIV/AIDS Prevention, and the American Social Health Association, STDs in America (Dec 1999).